"Progress report encouraging..."

"Bigger role for pharmacist boosts quality of care, safety in Saskatchewan nursing homes..."

"Small steps add up to big gains for Sask ICUs..."

HEALTH QUALITY

Quality Health Care: Your goal and ours.

The Health Quality Council is an independent agency that measures and reports on quality of care in Saskatchewan, promotes quality improvement, and engages its partners in building a better health system. The Council is the first of its kind in Canada. It is led by an appointed panel of provincial, national, and international health leaders.

Our vision:

To make Saskatchewan health care better.

Our mission:

To improve the quality of care and the caring experience in Saskatchewan, by encouraging the use of best practice. We will do this by:

- Ensuring continuous, objective reporting on performance/quality
- Supporting quality improvement initiatives
- Engaging all decision-makers – managers, providers, and patients – in the quality improvement movement

Our definition of quality:

Quality health care is care that is accessible, safe, effective, patient-centred, timely, efficient, and equitable.

Our values:

- Changing the culture
- Sharing successes and learning
- Engaging patients
- Partnering with managers and providers
- Basing improvement on evidence
- Organizing for results

Our mandate:

- Monitor standards of care
- Research and develop new standards for care
- Assess prescribing and use of prescription drugs
- Oversee drug approval processes
- Review new technologies
- Promote training and education programs
- Monitor and assess quality of services
- Explore human resource issues

Contents

The Honourable Len Taylor
Minister of Health
Room 361, Legislative Building
Regina, Saskatchewan
S4S 0B3

Dear Mr. Taylor:

I am pleased to submit the annual report for the Health Quality Council. This report for 2006-2007 fiscal year is submitted in accordance with the requirements of *The Health Quality Council Act* and *The Tabling of Documents Act*.

Dan Florizone
Board Chair
Health Quality Council

Message from the Board Chair

The theme of this year's annual report is, "Health Headlines: Make Way for the Good News," which seems appropriate given how dedicated Canadians are to following current events. A 2004 poll found 67% of Canadians watch television news each day, and 42% of us read a newspaper daily. Even more fascinating are the results of a study that looked at the content of news in Canada. Would it surprise you to learn that health care dominates the news, accounting for 65% of all stories? Clearly, we want to know what's happening in our world, particularly when it comes to our health care.

The sheer volume of health information out there is a reflection of the challenges in our health care system. With so many things to choose from, how do we know what our priorities should be for improving care? With so much information available, how do we know what we should be measuring to monitor quality?

Aligning priorities

The Health Quality Council began a major consultation process with our health system partners this past September – continuing the work of a strategic planning session in December. As a group, we shared our thoughts on common issues and discussed how to focus our efforts to make the best use of our limited resources, human and otherwise. We are confident that aligning our activities with the priorities of health system partners in the regional health authorities and the Saskatchewan Cancer Agency, as well as with allied health organizations, professional associations, and the academic community, will help spread and sustain improvements to quality of care.

We also talked about what alignment means from the patient perspective. The complete journey of care for patients crosses regional and professional boundaries. Their expectation is that they will receive the same high quality of care regardless of location or provider. Patients should be able to trust that all parts of the system are working in unison to ensure the best possible outcome for them.

Common measures, common understanding

We continued to work closely this past year with government, regional health authorities, and the Saskatchewan Cancer Agency on aligning measurements for accountability and quality. The Health Quality Council is an active participant on the Joint Committee on Performance Management (JCPM) initiative led by Saskatchewan Health. This group is working to deliver a system-wide cascade of indicators. From "top shelf" measures of system performance for health boards and the public, through to micro-level measures for use by front-line providers, we need this information to help guide our decisions.

Regions need a common menu of program- or unit-level measures from which to inform them of the quality of care they deliver, and to choose where they focus their improvement efforts. While RHAs need the flexibility to address those areas most important to them, defining and measuring quality the same way across our health system ensures that they can discuss their progress with each other and share successful practices.

Those are just two examples of how the Health Quality Council is working with its health system partners to provide the highest quality of health care to Saskatchewan citizens. It has been my privilege as the new Board Chair to have a "front-row seat" to the amazing efforts and unwavering commitment of a diverse group of people. The Health Quality Council and our health system partners share a common goal: we want the citizens of this province to have the best health care possible. Sharing priorities and indicators brings us one big step closer to achieving that.

Dan Florizone
Board Chair

It seems that you can't pick up a newspaper or turn on the radio today without hearing a health care story. In most cases, what we hear is negative – a hospital death due to a mishap that could have been prevented, a drug given in error, a patient suffering needlessly while waiting for surgery. As a population itself, we hear about the relentless increase in prevalence of diabetes, rising rates of heart disease in First Nations populations, a growing obesity epidemic.

For those of us who work in the health care system, stories such as these can be bewildering and demoralizing. We want to do the best for our patients, but we don't know where to start. We feel so busy with our day to day clinical duties that we don't have the time to stop what we are doing and fix the system. Even if we want things to change, the complexity of the system overwhelms us.

The solution to this is not to pretend that the problems in our system don't exist, or to underrate their importance. We owe it to each of the patients we serve to make things better. Hearing the "bad" news stories tells us know where we need to improve. But it's just as important to share the good news stories, the areas we might learn from.

This year the work of the Health Quality Council has been in the news a number of times. Through close working relationships with our partners, we have created examples where health care workers have overcome major obstacles to change and made major improvements to quality. These successes are not just those of the HQC, but are ones that are shared by all who have contributed to their success. I am intensely proud of the hard work and commitment to better health care that each of these stories embodies.

- In less than one year, participants in the Saskatchewan Chronic Disease Management Collaborative have improved care and outcomes for more than 8,000 people living with coronary artery disease and diabetes.
- Involving pharmacists on care teams is improving drug management for our seniors living in long-term care homes.
- A new tool is helping health providers treat and prevent pressure ulcers among residents of Saskatchewan long-term care homes.

Sharing these good news stories gives people hope and shows that change is possible. These stories can also bring momentum to further changes that need to take place in order to spread the improvement throughout the entire system.

Not every good news story becomes a headline. Improvement teams may not make the front page each time they attend a learning workshop. But these sessions are building capacity for regions to generate more and more good news stories for patients across the province. We might not get reporters calling us up to find out about the Adult Intensive Care Unit database. But for the health care providers using it to track quality of care – and the patients receiving that care – this, too, is a major news.

Let's continue sharing our good news stories so that we can all learn and spread improvement. And let's listen to the other health stories – those that make us uncomfortable but must be heard – and together set an ongoing with courage and conviction.

Ben Chan, MD, MPH, MPA
Chief Executive Officer

"Health care spending in Canada to reach $148 billion this year – infants and seniors account for highest spending per capita...."

Health Day News, December 6/2006

"Canada ranks poorly in adopting new techniques in primary care..."

The Medical Post, November 14/2006

When we see headlines about the costs of our system and the challenges it faces, it can be overwhelming. What will it take to create an effective, efficient, safe health care system that responds to the needs of our citizens?

- We need to have a **vision**, one that includes the values and input of our stakeholders. We are building a new strategic plan that incorporates priorities and interests expressed by our stakeholders at an innovative and dynamic planning session held in December 2006.

- We need to know how **measurement** can support quality improvement. Many headlines focus on how much money we spend, but perhaps a more important question is: What do we get for that investment? This year, we've been working with our health system partners to identify the "big dots," those high-level measures that will tell us how our provincial health system is doing in improving care. We've also been asking our stakeholders what data they need to drive improvement.

- We need to continue building **capacity** for quality improvement. Each of us has a role to play in improving care, whether the role is in leadership, as a front-line provider, or as a member of the public. Ensuring that we have the skills to engage in quality improvement is essential to spread and sustainability.

- We need coordinated quality improvement teams and projects. While we recognize that unique needs demand flexibility, we also know that **alignment** is a powerful force for improvement. Resources will always be finite, but by working together we can make the best use of what we have.

- We need an **engaged public**. It is essential that patients become more active and informed partners in their care. This year, we sought the public's input on what individuals and communities can do to improve chronic disease management.

"Sask. moving in right direction on key issues, albeit slowly: SMA..."

Medical Post, November 21/2006

Vision is a commitment to achieving that which is not yet realized, but is possible through determined effort. This past year we worked with health care providers, managers, and decision-makers from across the province to define a common vision. These consultations have guided us in determining specific strategies and priorities that are meaningful to our health system partners and will make the biggest difference for patients and their families.

Our vision is of a high-performing health care system, with all stakeholders committed to addressing gaps in quality. This year we moved several steps closer to achieving the alignment of purpose that will accelerate improvement.

"Group slams inconsistent cancer care..."
National Post, February 6/2007

Aligning a vision for quality in Saskatchewan

December 6, 2006 – Providers, managers, and decision-makers from across Saskatchewan's health care system see managing and preventing chronic disease, patient safety, and system flow and access as top priorities for improving the quality of care.

Close to 200 stakeholders from across the province gathered in Saskatoon this week to identify key issues and strategies for improving Saskatchewan's health care system. The focus of the innovative strategic planning process was to address the question: *What do we need to do to work together to make the quality of health care in Saskatchewan the best in the world?* Over the course of two full days, participants explored health care issues and began developing action plans for quality improvement.

In all, participants formed approximately 100 discussion groups, with topics ranging from emergency room capacity to citizen-led engagement. Participants then engaged in a multi-voting exercise to identify the priority areas of focus and the key lines of business that HQC should focus on in the future. Participants voiced strong support for more Collaboratives and other large-scale quality improvement initiatives, capacity building, training activities, and quality measurement tools and activities.

The discussions will form the basis of the Health Quality Council's 2007-2010 strategic plan.

"Heart and stroke disease more likely to cripple than kill..."

Montreal Gazette, March 29/2007

"Study says diabetes risk same as aging 15 years..."
Times Colonist, June 30/2006

"Medical errors kill 24,000 annually: Report..."
Montreal Gazette, March 29/2007

"Cheaper to prevent than treat bedsores, researcher says; more studies needed..."
Edmonton Journal, August 25/2006

There's no doubt that our health care system faces major challenges. But this year has been about meeting some of those challenges. We've seen some impressive improvement in managing two high-impact chronic diseases, diabetes and coronary artery disease. We've demonstrated that giving pharmacists an enhanced role on care teams can improve the drug management of seniors living in long-term care. We've also seen adult intensive care units improve patient safety, through better control of sedation/agitation and prevention of venous thromboembolism.

This year we launched two new improvement projects in response to HQC reports. The Improving Breast Cancer in Saskatchewan Modified Collaborative is focusing on ways to reduce wait times in the breast cancer care process. The Patient-Centred Discharge Modified Collaborative is working to improve patient flow and communication in the acute care discharge process.

The past year has also been about improving care in areas that don't always make the headlines, but are just as important to patients' quality of life. Pressure ulcers are a major concern to patients with limited mobility. Thanks to a newly adapted tool, and the pilot sites willing to test it, we are doing a much better job of preventing and treating pressure sores.

Major advances in improving patient safety in adult ICUs

April 10, 2006 – Critical care patients in Saskatchewan are receiving better treatment as a result of a year-long quality improvement initiative involving eight adult intensive care units (ICUs) in the province.

Teams from hospitals in Prince Albert, Moose Jaw, Saskatoon, and Regina improved two aspects of care that affect most critically ill patients: prevention of potentially harmful blood clots called venous thromboembolism (VTE) and control of sedation/agitation. Among the improvements:

- Patients were receiving appropriate treatment to prevent VTE on 100% of days in the final three months of the initiative. Before the start of the project, patients were receiving appropriate preventive treatment on just 60% of days.
- In the last three months of the project, patients were sedated at ideal levels on between 78% and 92% of days. In July 2005,

Close to 8,000 Saskatchewan people with diabetes and heart disease receiving improved care, having better outcomes

February 23, 2007 – In just less than one year, health care providers participating in a major province-wide initiative have improved care and health outcomes for nearly 8,000 mostly female people living with diabetes and coronary artery disease (the most common form of heart disease).

A progress report on the Chronic Disease Management (CDM) Collaborative shows that more patients are receiving the recommended drugs, tests, and services needed for managing their conditions. As well, patients are experiencing improved access to timely preventive appointments.

Since the Collaborative started until January 2007:

- 1,445 more patients living with diabetes received a urine microalbumin screening test, a 20% improvement. This test measures kidney damage due to diabetes, and is an important part of ongoing care.
- 643 more patients living with diabetes have achieved good control of blood sugar (A1C test than or equal to 7.0%), a 3% improvement.
- 778 patients living with coronary artery disease (CAD) were newly prescribed antiplatelet therapy (also known as ASA or Aspirin), a 9% improvement. ASA helps prevent blood clots.
- 134 more patients living with CAD have reached a healthy blood pressure level of less than 140/90, a 3% improvement.
- 82% of patients are getting family clinic appointments on the day of their choice.

A Collaborative is a method for rapidly spreading use of best practices among health care providers. The CDM Collaborative is focused on improving the quality of care for people with diabetes and CAD, and improving access to proactive practices. It is the largest quality improvement initiative in Saskatchewan's history: approximately 25% of the province's family physicians have joined the first and second wave of the Collaborative.

Each regional health authority has created and is supporting a multi-disciplinary quality improvement team. The literature shows that teamwork among health providers is key to improving care. Teams include family physicians/general practitioners and nurse practitioners as well as other health care providers, such as dietitians, nurses, pharmacists, diabetes educators, Tele-Health/Mobile program staff, and others. Approximately 400 health care professionals are involved in Wave 1 of the Collaborative.

"Participating in the Collaborative has been a great opportunity to develop more effective teamwork not just within our practice, but also within the region," says Mike Miller, Nurse Practitioner for the Leader Medical Clinic. "We're working together to offer more coordinated, standardized care. We're proud to see how these efforts have improved quality of care for our patients."

These preliminary results are for Wave 1 of the project, a second wave, involving 40 more practices, started in November 2006 and will run until March 2009.

Tool helping treat and prevent pressure ulcers

February 27, 2007 – Residents of Saskatchewan long-term care homes are getting fewer pressure ulcers and better treatment when ulcers occur, thanks to an improvement project led by the Health Quality Council and Saskatchewan Association of Health Organizations (SAHO).

As part of a year-long pilot study, HQC, SAHO, and a group of skin and wound care experts adapted for use in Saskatchewan "best practice" guidelines from the Registered Nurses' Association of Ontario. There was a 61% decrease in the number of new pressure ulcers (incidence) and 58% decrease in total number of new and existing ulcers (prevalence) at seven long-term care homes that implemented the new evidence-based guidelines on preventing and treating the ulcers.

Pressure ulcers develop when constant force against the skin reduces blood flow to certain parts of the body. The ulcers are common among people who cannot move without assistance. In particular but, elderly people or individuals of any age who spend a lot of time in bed or a wheelchair. The most common places for pressure ulcers are over bones close to the skin (elbow, heels, hips, ankles, shoulders, neck, and the back of the head). Pressure ulcers affect patients' quality of life and cost the health system more in staff time for wound care and in purchasing bandages and other supplies.

The Saskatchewan Skin and Wound Care Guidelines which also include recommendations on

preventing and caring for lower leg ulcers – have since been distributed to approximately 1,000 care providers around the province. An article on the project, "Evaluating the Implementation and Outcomes of the Saskatchewan Pressure Ulcer Guidelines in Long Term Care Facilities," was published in the February 2007 issue of Ostomy Wound Management, a peer reviewed medical journal.

Patient experience a launching pad for improvement project

March 15, 2007 – The transition from hospital to home promises to become a more efficient one for patients over the next year. Eight health regions have committed to participating in the Patient Centred Discharge Modified Collaborative (P-CDMC), a project designed to improve patient flow and communication/education when people are leaving hospital.

The regions are acting on the results of a 2006 patient experience survey which found only 51% of patients knew what medication side effects to watch for, 58% understood when to resume normal activities, and just 59% knew the warning signals to watch for at home related to their disease condition. Improving the discharge process can reduce readmissions, improve medication adherence, and lead to greater patient satisfaction.

Fourteen teams are participating in the P-CDMC. Participating regions are: Mamawetan Churchill River, Prairie North, Kelsey Trail, Saskatoon, Sunrise, Cypress, Five Hills, and Sun Country. Improvement teams will be trying out ideas such as using discharge checklists and setting an estimated date of discharge. Throughout the project, teams will track their results on a monthly basis and connect regularly with each other to share good ideas and lessons learned.

Meanwhile, the second round of the Patient Experience Survey kicked off in February 2007, with all 13 health regions again participating. One of the most exciting changes this time around is that surveying will be ongoing, rather than for a single period of time. This will provide regions with regular feedback on the patient experience. The survey has also been updated with several new questions about patient safety, which should yield important information for improving this aspect of hospital care.

Improvement projects underway for breast cancer care

March 16, 2007 – Breast cancer care in Saskatchewan might soon be as efficient as building a Toyota. Patients and providers gathered in Saskatoon today to learn more about the Lean method, an approach that looks at each step in a process and finds ways of adding value and increasing efficiency. The technique was developed by Toyota, but in recent years has been applied to health care.

Improvement teams from Regina, Saskatoon, and Cypress Health regions attended the workshop. All three teams are working on projects aimed at reducing waits from surgery to first oncologist visit. The Saskatchewan Cancer Agency team is focused on reducing the time between first radiation oncologist appointment and first radiation treatment.

Teams will be working on improvements over the next year as part of the Breast Cancer Care Modified Collaborative. The Collaborative is being sponsored by the Health Quality Council.

Bigger role for pharmacist boosts quality of care, safety in Saskatchewan nursing homes

March 29, 2007 – Involving pharmacists more closely in the drug treatment of Saskatchewan seniors living in long-term care yields better, safer care. That's the key finding from HQC's year-long demonstration project led by the Health Quality Council.

The project tested an enhanced role for pharmacists, one that included spending time talking to residents and their families, participating in rounds, and reviewing residents' medications. Medication reviews identified an average of 2.5 drug related problems for each senior. The most common problem was that residents were on drugs for which there was no medically valid reason documented in their medical chart.

Care teams made 792 recommendations in response to medication reviews. Forty-three per cent (339) of the recommendations were to stop one or more drugs, 26% (206) were to change dosage or interval, and 14% (112) were to start a new drug. Physicians accepted most of the recommendations made by care teams.

The demonstration project was started in response to a 2004 HQC report which found many Saskatchewan seniors living in long-term care are on drugs that increase their risk of dizziness, falls, and confusion. Research from elsewhere shows that giving pharmacists a more active role improves care in nursing homes and provides a great resource for other members of the care team. HQC provided the participating long-term care homes with quality improvement support and some funding to pay pharmacists for their increased involvement.

Operations research used to help understand, improve patient flow

March 31, 2007 – The same expertise used to shorten lines at Disneyland is now helping improve patient flow in Saskatchewan's health care system. Operations research (OR) is an approach that looks at system issues (patient flow and capacity) and uses simulation software to test the impact of potential solutions. Two projects, supported through the Technical Efficiency Fund (TEF), are using OR to improve patient flow in the emergency department and access to speech language therapy services.

The Health Quality Council, together with Saskatoon and Regina Qu'Appelle health regions, used operations research to analyze wait times in the emergency department (ED). The first part of the project looked at data on wait times for approximately 1,800 patients. It showed that patients spent an average of two hours in emergency. Phase 2 of the project (an ongoing effort, with quality improvement teams conducting plan-do-study-act (PDSA) cycles and developing computer simulation models) to test ideas for improving patient flow, streamlining processes, and reducing wait times in the ED.

The second TEF project looked at improving access to Speech Language Pathology (SLP) services in the Prince Albert Health Region. In the last three years, the average number of children referred each month for speech/language therapy had tripled. Wait times from referral to first assessment were well in excess of one year, and one-fourth of patients did not even get assessed.

After developing a map of how patients flow through the system, SLP therapists and their staff identified several ideas for improving wait times and system efficiency. The Health Quality Council then created a simulation model of the current system to test the potential impact of those changes. The modeling generated information for planners to use in making decisions about program design and resource allocation. SLP therapists in Prince North have recently begun using these scheduling and group processes. In addition, the region has created two new positions for support staff.

"Healthcare No. 1 priority for voters, poll indicates..."

CanWest News, June 6/2006

"Patients easily influenced by online health info..."

Medical Post, November 14/2006

A change is an improvement only if the patient thinks it is. We took a major step forward this year in engaging Saskatchewan residents in quality improvement. The public's knowledge about quality ultimately creates accountability in the system. Our October forum on public reporting shed light on what citizens want to know about quality, and how this information should be presented. Our public meeting in March was another opportunity to hear the patient voice. People from across the province took time to share ideas on how their community could manage and prevent chronic disease. Not only were a host of great ideas generated, but the event provided patients an opportunity to share their experiences. As one participant said, "I'm not an expert in diabetes, but I am an expert in *my* diabetes."

Reporting on health care quality and safety: What people want to know

October 30, 2006

A community approach to chronic disease management

March 27, 2007

"No way to tell if medical wait times improving: report..."

Broadcast News, November 29/2006

"Breast cancer patient upset by long wait for further treatment..."
The Star Phoenix, July 10/2006

You can't manage what you don't measure. Measurement is the difference between thinking you are providing good care, and knowing it. Measurement can tell us how long women in Saskatchewan are waiting for breast cancer treatment – and how they feel about their waiting time. Data on surgery volumes can shed light on the optimal number of surgeries that should be performed for better patient outcomes.

This year we embarked on an initiative to make data readily available for use in quality improvement projects. The Adult Intensive Care Unit database builds on the work of the Adult ICU Collaborative, providing a tool for teams to track their improvements.

Tracking quality for better patient safety

October 1, 2006 – Saskatchewan's adult intensive care units have taken a major step forward in detecting errors, reducing harm, and increasing safety for their patients. The Health Quality Council, in partnership with Saskatchewan's two largest health regions, has designed a secure, web-based database that will be used to collect patient-level data and report on selected measures of quality. Units will be able to easily monitor, and quickly generate reports about, their performance.

Intensive care units are among the most complex care environments in the health system. Not only do they serve the most critically ill patients, but patients are also exposed to potentially harmful interventions. How risky is it? Studies suggest that one in five patients may experience an adverse event during their stay in the intensive care unit.

It is expected the new database will enhance quality of critical care in Saskatchewan by enabling systematic monitoring, providing benchmarking information, and supporting teamwork among adult ICUs.

Saskatchewan women say breast cancer care takes too long

October 5, 2006 – Breast cancer care in Saskatchewan takes longer than what women say is reasonable and longer than suggested guidelines, according to a Health Quality Council report. The typical overall time for care is four months and for many women it is much longer.

The Council measured overall time from clinical detection of an abnormality until a woman begins treatment, and times for the following steps in the care process:

- Screening mammography to family physician visit;
- Family physician visit to diagnostic imaging;
- Family physician visit to diagnosis (biopsy);
- Diagnosis to surgery; and,
- Surgery to adjuvant therapy (chemotherapy, radiation therapy, or hormone therapy).

The longest time (typically 62 days) occurred between surgery and the start of adjuvant therapy.

The Health Quality Council also surveyed women who were diagnosed with breast cancer in 2003 and 2004 about their care experiences. Half (51%) of the 716 women who responded to the survey said they experienced unnecessary anxiety during at least one part of their care. Women felt most anxious during diagnosis and treatment and least anxious during the surgery phase. In addition, nearly half (47%) of women reported feeling out of control during at least one phase of their cancer care.

In response to the study, HQC and the Saskatchewan Cancer Agency have set up quality improvement teams to reduce times for certain phases of care.

Practice makes for better surgical outcomes

March 31, 2007 – Are Saskatchewan surgeons performing the optimal number of certain procedures? That's the question behind the Health Quality Council's latest study on the relationship between volumes of surgeries performed and patient outcomes.

Research shows that quantity impacts quality for certain surgeries. Hospitals and surgeons that do higher volumes of some procedures tend to have better patient outcomes, including lower mortality rates. The HQC study will look at average number of procedures performed in Saskatchewan hospitals and 30-day mortality rates for three categories of procedures: cancer resections, vascular, and cardiac procedures. Results are expected to be released in Summer 2007.

"Campaign finds ways to prevent hospital errors..."

CTV News, March 28/2007

"Finger pointing hurts health care..."
Star Phoenix
April 28/2006

"Our right to quality health care..."
National Post,
June 2/2006

This year we've seen some amazing growth in partnerships and in the spread of the quality improvement culture. The momentum is building and so is capacity. This year we continued working with our key partners, but also started developing new partnerships – with the boards of regional health authorities and the academic community.

This year also saw us sharing our improvement stories with national and international audiences. Whether in Edmonton or Barcelona, people are excited about the work being done in Saskatchewan.

More Saskatchewan content in IHI broadcast this year

December 12, 2006 – This year's Saskatchewan broadcast of the IHI National Forum on Quality Improvement illustrates just how much the QI culture has grown in this province. The 2006 edition of this event featured more local content than ever before.

Among the stories featured were:

- Profiles of two family physician practices participating in the Saskatchewan Chronic Disease Management Collaborative;
- Results from a project aimed at reducing readmissions for congestive heart failure;
- An update on how one Saskatoon team is shortening wait times for breast cancer care;
- Highlights from projects that are improving dysphagia and drug management for seniors in long-term care; and,
- A demonstration of the adult intensive care unit QI database.

More than 550 people from across the province attended this year's broadcast, which HQC hosted in partnership with the University of Saskatchewan's College of Nursing.

A new direction for the Quality Improvement Network (QIN)

June 8, 2006 – Although the original agreement launching the Quality Improvement Network has drawn to a close, its members want to continue their work promoting and supporting quality improvement in Saskatchewan. QIN representatives met in Saskatoon today to chart a new direction for the group.

The most significant change is to the QIN membership. Although previously open only to health regions and the Saskatchewan Cancer Agency, the group has decided to open up membership to any health care partner interested in quality improvement.

Under the new charter QIN will meet four times per year. The main activities of the group will be sharing knowledge about quality improvement, building capacity through learning opportunities, coordinating quality initiatives, and supporting leadership for quality improvement.

Need help juggling quality improvement teams? Try Coach Approach

June 23, 2006 – Making the transition from "doer" to coach can be difficult for leaders. Today the Health Quality Council rolled out a new quality improvement training clinic designed to make that change easier. The Coach Approach workshop is for quality improvement teams and leaders who want to build leadership skills to support improvement teams. Participants learn how to move from the hands-on work to nurturing and developing these skills in others.

Coach Approach is the second quality improvement workshop offered by the Health Quality Council. The first, Teams and Leaders in Quality Improvement Training (TLQIT), is a basic course in quality improvement science that covers the Model for Improvement, PDSA cycles, process mapping, and other general QI concepts. The new Coach Approach workshop goes a step further, teaching participants how to take these QI skills and develop them in their own teams. It covers topics such as group development, active listening, and asking good questions.

Both Coach Approach and TLQIT are offered throughout Saskatchewan. Since launching the workshops in 2004, HQC has provided training to more than 1,400 health care workers (3.5% of the workforce) and supported approximately 135 quality improvement teams across the province. HQC is currently planning a third type of clinic, this one focused on measurement for improvement.

RHA boards have key role in quality improvement

October 25, 2006 – The currency of leadership is attention. That was one of the key messages presented to board members of Saskatchewan's regional health authorities yesterday at an education session led by the Health Quality Council. Dan Florizone, HQC chair and CEO of Five Hills Health Region, says that in order for boards to fulfill their oversight role, they need measures that cover the entire health care system, with the right level of detail and a balanced view of quality. "Board members have a vital role in monitoring and improving the quality of health care for their residents," says Florizone. "Unfortunately, they often receive too much information or the wrong balance of information." Each region's vision for quality must also include measurable targets with time frames, so that boards can monitor current performance on strategic priorities, he said.

The Council's presentation yesterday was the first step in a broader strategy to engage more closely with RHA boards about their important role in quality improvement. Next steps include sponsoring the board education track at SAHO's 2007 conference in Saskatoon.

Engaging faculty and students in quality improvement

March 31, 2007 – This year HQC began building the foundation for engaging faculty and students from a variety of health disciplines in quality improvement. Linking more closely with the academic community is key to spreading and sustaining improvement. Over the next year, HQC will be working closely with academic stakeholders to develop and implement initiatives for educating the next generation of health care professionals on quality improvement.

Health Quality Council presents at national, international events

March 31, 2007 – It was a busy year for the board and staff of the Health Quality Council, as they were invited to present at a number of national and international conferences:

- Institute for Healthcare Improvement National Forum on Quality Improvement – Orlando, Florida
- International Forum on Quality and Safety in Health Care 2007 – Barcelona, Spain
- Knowledge Utilization Conference 2006 – Minneapolis, Minnesota
- RNAO International Eldercare Conference – Markham, Ontario
- Insight Health Care Policy Summit April 2006 – Toronto, Ontario
- Stats Canada/CIHI Health Data Users Conference 2006 – Vancouver, British Columbia
- Canadian Operational Research Society National Conference – Montreal, Quebec
- National Forum on Knowledge Transfer and Exchange – Toronto, Ontario
- Young Leaders' Forum – Ottawa, Ontario
- ICES Conference – Toronto, Ontario
- Ontario Primary Healthcare Transition Team – Toronto, Ontario

"Health staff have new tool against blood clots: checklist..."

Prince Albert Daily Herald, April 11/2006

"Second stage in health collaborative under way..."

Saskatoon Sun, June11, 2006

"New method could cut cancer treatment wait..."

Star Phoenix, March 17, 2007

HQC begins new fiscal year with positive expectations; plans to build on all the good news from last year

April 1, 2007 – Today marked the start of the Health Quality Council's new fiscal year, and launch of the agency's 2007-2010 strategic plan. The vision outlined in that document–that Saskatchewan patients will have the highest quality of health care–is bold. However, HQC and its partners have over the past few years laid significant groundwork that will help move the province's health care system forward toward this ideal.

Health providers and managers made major gains in closing the gap between evidence and practice. Projects focused on improving quality of care and patient safety in adult ICUs, primary care practices, and long term care facilities have demonstrated that system-wide change is not only possible but is happening across this province. The past year also saw advances in our use of measurement for improvement, increasing our understanding of wait times in breast cancer care and leading to development of a database for tracking improvement in Adult ICUs.

The new strategic plan will build on a growing culture of quality improvement in Saskatchewan, a culture more evident last year than ever before. Indicators such as increased Saskatchewan content in the IHI satellite broadcast, enthusiastic participation by our health care partners in discussion forums, and greater engagement with citizens of the province, all point to a strong provincial commitment to quality improvement.

Dr. Ben Chan, CEO of the Health Quality Council, says he's proud of the many good news QI stories from around the province that have made the headlines this year. "Each one represents better quality of care for patients and their families," says Chan. "With the support and commitment of our health system partners, we are confident that this province can achieve the best health headline of all: that we have the highest quality of care in the world, right here in Saskatchewan."

Health Quality Council Staff

Board of **Directors**

Dan Florizone
(Chair)

Marlene Smadu
(Vice-Chair)

Ross Baker

Peter Barrett

Charlyn Black

John Conway

Daniel Fox

Eber Hampton

Cecile Hunt

Dennis Kendel

Steven Lewis

Stewart McMillan
(Term completed)

Yvonne Shevchuk

For the year ended March 31, 2007

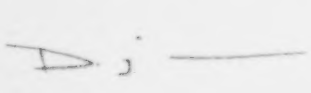
Management is responsible for the integrity of the financial information reported by the Health Quality Council (HQC). Fulfilling this responsibility requires the preparation and presentation of financial statements and other financial information in accordance with Canadian generally accepted accounting principles that are consistently applied, with any exceptions specifically described in the financial statements.

The accounting system used by the HQC includes an appropriate system of internal controls to provide reasonable assurance that:

- transactions are authorized;
- the assets of the HQC are protected from loss and unauthorized use; and
- the accounts are properly kept and financial reports are properly monitored to ensure reliable information is provided for preparation of financial statements and other financial information.

To ensure management meets its responsibilities for financial reporting and internal control, Board members of the HQC discuss audit and financial reporting matters with representatives of management at regular meetings. HQC Board members have also reviewed and approved the financial statements with representatives of management.

The Provincial Auditor of Saskatchewan has audited the HQC's statement of financial position, statement of operations, statement of changes in net financial assets, and statement of cash flows. His responsibility is to express an opinion on the fairness of management's financial statements. The Auditor's report outlines the scope of his audit and his opinion.



Dan Florizone
Board Chair

Ben Chan, MB, MPH, MPA
Chief Executive Officer

Saskatoon, Saskatchewan
May 11, 2007

To the Members of the Legislative Assembly of Saskatchewan

I have audited the statement of financial position of the Health Quality Council as at March 31, 2007 and the statements of operations, change in net assets and cash flows for the year then ended. The Council's management is responsible for preparing these financial statements for Treasury Board's approval. My responsibility is to express an opinion on these financial statements based on my audit.

I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these financial statements present fairly, in all material respects, the financial position of the Health Quality Council as at March 31, 2007 and the results of its operations and its cash flow for the year then ended in accordance with Canadian generally accepted accounting principles.

Fred Wendel, CMA, CA
Provincial Auditor

Regina, Saskatchewan
May 11, 2007

STATEMENT 1
HEALTH QUALITY COUNCIL

As at March 31	**2007**	**2006**
	(000's)	(000's)
Financial Assets		
Cash	$ 718	$ 1,940
Accrued interest receivable	15	9
Accounts receivable		
-Saskatchewan Health - General Revenue Fund (Note 5)	500	-
-Other	44	46
Short-term investments (Note 3)	1,996	2,182
	3,273	4,177
Liabilities		
Accounts payable	669	1,164
Payroll liabilities	135	128
Deferred revenue - Technical Efficiency Fund (Note 5)	866	765
	1,670	2,057
Net Financial Assets	1,603	2,120
Non-Financial Assets		
Tangible capital assets (Note 2b & Note 4)	93	150
Prepaid expenses	25	11
	118	161
Accumulated Surplus	$ 1,721	$ 2,281

Contractual commitments (Note 11)

(See accompanying notes to the financial statements)

STATEMENT 2
HEALTH QUALITY COUNCIL

For the year ended March 31

	2007		2006
	Budget (Note 9) ('000's)	Actual ('000's)	Actual ('000's)
Revenue:			
Saskatchewan Health			
- General Revenue Fund	$ 5,000	$ 5,000	$ 5,000
- Technical Efficiency Fund (Note 5)	-	418	260
Interest income	-	119	82
Other income (Note 6)	-	105	23
	5,000	5,642	5,365
Expenses:			
Project funding	1,702	1,538	933
Grants	407	582	1,054
Wages and benefits	3,022	2,951	2,850
Travel	221	190	182
Administrative and operating expenses	803	468	510
Honoraria and expenses of the board	185	130	171
Amortization expense	100	93	103
Rent	260	250	247
	6,700	6,202	6,050
Annual Deficit	$ (1,700)	(560)	(685)
Accumulated Surplus, beginning of year		2,281	2,966
Accumulated Surplus, end of year		$ 1,721	$ 2,281

(See accompanying notes to the financial statements)

STATEMENT 3
HEALTH QUALITY COUNCIL

For the year ended March 31	2007	2006
	(000's)	(000's)
Annual Deficit	$ (560)	$ (685)
Acquisition of tangible capital assets	(36)	(23)
Loss on disposal of tangible capital assets	-	1
Amortization of tangible capital assets	93	103
	57	81
Acquisition of prepaid expenses	(25)	(11)
Use of prepaid expenses	11	10
	(14)	(1)
Decrease in net financial assets	(517)	(605)
Net financial assets, beginning of year	2,120	2,725
Net financial assets, end of year	$ 1,603	$ 2,120

(See accompanying notes to the financial statements)

STATEMENT 4
HEALTH QUALITY COUNCIL

For the year ended March 31	2007 (000's)	2006 (000's)
Operating Activities:		
Cash Received From:		
Saskatchewan Health - General Revenue Fund	$ 5,000	$ 5,000
Interest income	130	111
Other income	108	23
	5,238	5,134
Cash Paid For:		
Wages and benefits	2,946	2,817
Supplies and other	1,946	1,565
Project funding	1,158	676
Grants	582	644
	6,629	5,702
Cash used in operating activities	(1,391)	(568)
Capital Activities:		
Purchases of tangible capital assets	(17)	(23)
Cash used in capital activities	(17)	(23)
Investing Activities:		
Purchase of investments	(7,210)	(9,271)
Disposal of investments	7,396	10,955
Cash provided by investing activities	186	1,684
(Decrease) Increase in cash	(1,222)	1,093
Cash, beginning of year	1,940	847
Cash, end of year	$ 718	$ 1,940

(See accompanying notes to the financial statements)

HEALTH QUALITY COUNCIL
March 31, 2007

1. Establishment of the Council

The *Health Quality Council Act* was given royal assent July 10, 2002 and proclaimed on November 22, 2002. The Health Quality Council measures and reports on quality of care in Saskatchewan, promotes improvement, and engages its partners in building a better health system. The Health Quality Council commenced operations on January 1, 2003.

2. Accounting Policies

The Health Quality Council uses Canadian generally accepted accounting principles recommended by the Public Sector Accounting Board to the Canadian Institute of Chartered Accountants. The following accounting principles are considered to be significant:

a) Operations

For the operations of the Health Quality Council, the primary revenue is received from Saskatchewan Health - General Revenue Fund. Other sources of revenue include interest and miscellaneous revenue. Unrestricted contributions are recognized as revenue in the year received or receivable if the amount can be reasonably estimated and collection is reasonably assured.

Restricted contributions related to general operations are deferred and recognized as revenue in the year which related expenses are incurred.

b) Tangible Capital Assets

Tangible capital assets are reported at cost less accumulated amortization. Purchases valued at $250 or greater are recorded as a capital asset. Leasehold improvements are amortized over the length of the lease; the current lease expires in July 2007. Amortization is recorded on a straight-line basis at rates based on estimated useful lives of the tangible capital assets as follows:

Office Furniture	10 years
Office Equipment	5 years
Computer Hardware	3 years
Computer Software	3 years
Leasehold Improvements	3 years

Normal maintenance and repairs are expensed as incurred.

c) Investments

Investments are valued at the lower of amortized cost or net realizable value.

d) Basis of Accounting

The financial statements are prepared using the accrual basis of accounting.

3. Short-Term Investments

The Health Quality Council held three investments as of March 31, 2007. All investments are held with Saskatchewan Finance. Investments are short-term, held for a period of one year or less. The total investments include $246,478 for the Technical Efficiency Fund as established by Saskatchewan Health (Note 5). Investments will decrease over the next fiscal year, as the funds will be used to implement the Health Quality Council's strategic plan and approved projects in the Technical Efficiency Program. Total investments held as of March 31, 2007 were $1,996,032 (2006 - $2,181,674).

	2007	
	Carrying Value (000's)	Interest Rate
Sask Finance:		
RBC Capital Markets	$1,250	4.18%
Scotia Capital Markets	500	4.31%
Scotia Capital Markets	246	4.31%
Total Investments	$1,996	

4. Tangible Capital Assets

The recognition and measurement of tangible capital assets is based on their service potential. These assets will not provide resources to discharge liabilities of the Health Quality Council.

	Office Furniture & Equipment (000's)	Computer Hardware & Software (000's)	Leasehold Improvements (000's)	2007 Totals (000's)	2006 Totals (000's)
Opening cost	$ 143	$ 237	$ 51	$ 431	$ 439
Additions during the year	5	31	-	36	23
Disposals during the year	-	-	-	-	(31)
Closing cost	148	268	51	467	431
Opening accumulated amortization	65	182	34	281	208
Amortization for the year	17	59	17	93	103
Disposals during the year	-	-	-	-	(30)
Closing accumulated amortization	82	241	51	374	281
Net book value of tangible capital assets	$ 66	$ 27	$ -	$ 93	$ 150

5. Deferred Revenue - Technical Efficiency Fund

The Province of Saskatchewan established a $1 million Technical Efficiency Fund in February 2005. Saskatchewan Health has entrusted the Health Quality Council to manage and coordinate the Technical Efficiency Program, which is designed to assess and evaluate those areas of the health care system that the Province has determined could benefit from the application of one or more process improvements:

(a) health system productivity,
(b) timeliness of health care delivery and services,
(c) health outcomes, and
(d) overall patient, public and provider satisfaction with the health system.

A signed agreement describes the responsibilities of Saskatchewan Health and the Health Quality Council. Saskatchewan Health approves all projects and payments that are to be funded through the Technical Efficiency Fund. The original term of this agreement is March 1, 2005 to March 31, 2007. The agreement has been extended to March 31, 2008. Saskatchewan Health provided one-time incremental funding for the Technical Efficiency Program in the amount of $500,000 for fiscal year 2007-2008.

Deferred revenue of $418,193 (2006 - $260,408) was recorded as revenue as the related costs were incurred. Interest earned of $19,450 from investments of the Technical Efficiency Fund accrued to the benefit of the Fund. Unless otherwise directed by the Province, the HQC will return all unexpended funds to the province upon expiration of the agreement.

6. Other Income

The Health Quality Council and Saskatchewan Cancer Agency entered into an agreement to collaborate on a project to analyze and improve the care flow of breast cancer patients from time of suspicious finding to treatment. The Saskatchewan Cancer Agency contributed $80,000 to support costs associated with this project.

The University of Saskatchewan provided the Health Quality Council with $4,000 to second an employee to the Patient Centered Inter- professional Team Experiences (P-CITE). The employee will provide ninety (90) hours of facilitation and consultation to various committees.

Other income recorded by the Health Quality Council is comprised of conference registration fees, and cost recoveries.

7. Related Party Transactions

Included in these financial statements are transactions with various Saskatchewan Crown Corporations, departments, agencies, boards, and commissions related to the Health Quality Council by virtue of common control by the Government of Saskatchewan, and non-crown corporations and enterprises subject to joint control or significant influence by the Government of Saskatchewan (collectively referred to as "related parties"). Other transactions with related parties and amounts due to or from them are described separately in these financial statements and notes thereto. The list below describes related party transactions in excess of $10,000 in the current year.

Routine operating transactions with related parties are recorded at the standard rates charged by those organizations and are settled on normal trade terms.

The Health Quality Council pays Provincial Sales Tax to the Saskatchewan Department of Finance on all its taxable purchases. Taxes paid are recorded as part of the cost of those purchases.

	2007 ($ 000's)	2006 ($ 000's)
Revenue		
Saskatchewan Cancer Agency	$ 80	$ -
Project Funding, Adminstration & Occupancy Costs		
Capital Pension Plan	128	101
Regional Health Authorities	1,257	1,252
Sask Tel	10	16
Saskatchewan Associations of Health Organizations	25	35
Saskatchewan Cancer Agency	-	23
Saskatchewan Finance	17	20
Saskatchewan Health Information Network	302	195
Saskatchewan Opportunities Corporation	273	269
Saskatchewan Communications Network Corporation	-	34
University of Saskatchewan	91	110
Accounts Payable		
Capital Pension Plan	-	16
Regional Health Authorities	190	563
Saskatchewan Association of Health Organizations	11	-
Saskatchewan Finance	17	16
Saskatchewan Health Information Network	99	195
University of Saskatchewan	-	31

8. Financial Instruments

The Health Quality Council has the following financial instruments: accrued interest receivable, accounts receivable, investments, and accounts payable. The following paragraphs disclose the significant aspects of these financial instruments.

a) Significant terms and conditions

There are no significant terms and conditions associated with the financial instruments, other than investments, that may affect the amount, timing, and certainty of future cash flows. Significant terms and conditions for investments are described separately in these financial statements and notes thereto.

b) Interest Rate Risk

The Health Quality Council is exposed to interest rate risk when the value of its financial instruments fluctuates due to changes in market interest rates. The Health Quality Council does not have any long-term investments that may be affected by market pressures.

The Health Quality Council's receivables and payables are non-interest bearing.

c) Credit Risk

The Health Quality Council is exposed to credit risk from potential non-payment of accounts receivable or investment income and principal.

Most of the Health Quality Council's receivables are from provincial and federal governments. Therefore the credit risk is minimal.

All investments are purchased through Saskatchewan Finance and the investments held are either from major banks, or provinces. Therefore, credit risk for investments and related accrued interest receivable is minimal.

d) Fair Value

For the following financial instruments, the carrying amounts approximate fair value due to their immediate or short-term nature:

Accrued Interest Receivable
Accounts Receivable
Short-term Investments
Accounts Payable

9. Budget

These amounts represent the operating budget approved by the Board of Directors.

10. Pension Plan

The Health Quality Council is a participating employer in the Capital Pension Plan, a defined contribution pension plan. Eligible employees make monthly contributions of 6.35% of gross salary, which are matched by the Health Quality Council. The Health Quality Council's contributions for this fiscal year were $128,211 (2006 - $101,296 at a rate of 5.5% of gross salary).

11. Contractual Commitments

As of March 31, 2007, the Health Quality Council had the following commitments:

a) Office Rent

* The Health Quality Council has a lease for office space with the Saskatchewan Opportunities Corporation. The lease has been extended to July 31, 2012. The lease agreement includes a free rent period from April 1, 2007 to July 31, 2007. The monthly cost will be $20,364, for the period of August 1, 2007 to July 31, 2012.

b) National Research Corporation Canada

* The Health Quality Council has contracted the National Research Corporation Canada to conduct a survey regarding patient satisfaction throughout all Saskatchewan regional health authorities. The National Research Corporation Canada will be responsible for collecting, processing and reporting survey results to the Health Quality Council.

The work schedule establishes that the deliverables be provided by March 2008, with a cost of $96,005.

12. Comparative Financial Information

For comparative purposes, certain balances have been reclassified to conform to 2007 financial statement presentation.

To: The Members of the Legislative Assembly of Saskatchewan

I have audited Health Quality Council's control as of March 31, 2007 to express an opinion as to the effectiveness of its control related to the following objectives.

- To safeguard public resources. That is, to ensure its assets are not lost or used inappropriately; to ensure it does not inappropriately incur obligations; to establish a financial plan for the purposes of achieving its financial goals; and to monitor and react to its progress towards the objectives established in its financial plan.
- To prepare reliable financial statements.
- To conduct its activities following laws, regulations and policies related to financial reporting, safeguarding public resources, revenue raising, spending, borrowing, and investing.

I used the control framework developed by The Canadian Institute of Chartered Accountants (CICA) to make my judgements about the effectiveness of Health Quality Council's control. I did not audit certain aspects of control concerning the effectiveness, economy, and efficiency of certain management decision-making processes.

The CICA defines control as comprising those elements of an organization that, taken together, support people in the achievement of the organization's objectives. Control is effective to the extent that it provides reasonable assurance that the organization will achieve its objectives.

Health Quality Council's management is responsible for effective control related to the objectives described above. My responsibility is to express an opinion on the effectiveness of control based on my audit.

I conducted my audit in accordance with standards for assurance engagements established by The Canadian Institute of Chartered Accountants. Those standards require that I plan and perform an audit to obtain reasonable assurance as to effectiveness of Health Quality Council's control related to the objectives stated above. An audit includes obtaining an understanding of the significant risks related to these objectives, the key control elements and control activities to manage these risks and examining, on a test basis, evidence relating to control.

Control can provide only reasonable and not absolute assurance of achieving objectives reliably for the following reasons. There are inherent limitations in control including judgement in decision-making, human error, collusion to circumvent control activities and management overriding control. Cost/benefit decisions are made when designing control in organizations. Because control can be expected to provide only reasonable assurance and not absolute assurance, the objectives referred to above may not be achieved reliably. Also, projections of any evaluation of control to future periods are subject to the risk that control may become ineffective because of changes in internal and external conditions, or that the degree of compliance with control activities may deteriorate.

In my opinion, based on the limitations noted above, Health Quality Council's control was effective, in all material respects, to meet the objectives stated above as of March 31, 2007 based on the CICA criteria of control framework.

Regina, Saskatchewan
May 11, 2007

Fred Wendel, CMA, CA
Provincial Auditor

To: The Members of the Legislative Assembly of Saskatchewan

I have made an examination to determine whether the Health Quality Council, complied with the provisions of the following legislative and related authorities pertaining to its financial reporting, safeguarding public resources, spending, revenue raising, borrowing and investing activities during the year ended March 31, 2007:

The Health Quality Council Act
The Tabling of Documents Act, 1991
Orders in Council issued pursuant to the above Acts

My examination was made in accordance with Canadian generally accepted auditing standards, and accordingly included such tests and other procedures as I considered necessary in the circumstances.

In my opinion, the Health Quality Council has complied, in all significant respects, with the provisions of the aforementioned legislative and related authorities during the year ended
March 31, 2007.

Regina, Saskatchewan
May 11, 2007

Fred Wendel, CMA, CA
Provincial Auditor

HEALTH QUALITY COUNCIL

For the year ended March 31, 2007

Personal Services

The individuals listed below received payments for salaries and honorariums which total $50,000 or more.

Agnew, Alex	$	73,101
Basky, Greg		77,853
Bingham, Maureen		78,590
Brossart, Bonnie		114,366
Casganette, Paul		64,838
Chan, Ben		267,084
Delaney, Catherine		59,479
Flegel, Catherine		50,401
Furniss, Shari		51,191
Gander, Laura		80,106
Klomp, Helena		63,704
Rathgeber, Melanie		62,605
Sidhu, Nirmal		53,730
Smillie, Mary		50,488
Stevenson, Katherine		58,385
Teare, Gary		90,416
Timmerman, Tracey		59,846
Verrall, Tanya		62,857
Welch, Pete		58,795
Willoughby, Keith		79,376
Wohlgemuth, Nicole		53,115
Payees under $50,000		888,513
	$	2,498,839

Supplier Payments

The companies listed below represent those suppliers who were paid $50,000 or more for the provision of goods and services.

Capital Pension Plan	$	128,211
Cronus Technologies Inc.		73,721
Delta Hotels		60,309
Great West Life Assurance Company		106,934
Saskatchewan Health Information Network		302,494
Saskatchewan Opportunites Corporation		273,417
Saskatoon Health Region		55,843
University of Saskatchewan		87,732
Xwave		57,680
Suppliers under $50,000		787,179
	$	1,933,520

Transfers

The agencies listed below are transfer recipients that received $50,000 or more.

Cypress Hills Regional Health Authority	$	71,316
Five Hills Regional Health Authority		216,781
Prairie North Regional Health Authority		94,934
Prince Albert Parkland Regional Health Authority		51,859
Regina Qu'Appelle Regional Health Authority		319,389
Saskatoon Regional Health Authority		166,392
Sunrise Regional Health Authority		58,557
Transfers under $50,000		509,990
	$	1,489,218